



TAZEWELL COUNTY HEALTH DEPARTMENT CONSENT FORM
FOR CHILDREN UNDER AGE 12

Date: _____ Date of Birth: ____/____/____
Last Name: _____ Legal First Name: _____ (NO NICKNAMES) Middle Initial: _____
Address: _____ City: _____ State: Illinois Zip: _____
Email address: _____ Phone Number: _____

Insurance Information:

Yes, I have insurance coverage

Insurance Name: _____ (Examples: Molina, Medicare, Medicaid, Blue Cross Blue Shield, United Healthcare, UMR)

Policy or Subscriber ID: _____ Group Number (if any): _____

Policy Holder's Name: _____ Date of Birth: ____/____/____

No, I do not have any medical insurance coverage at all

Notice of Privacy Policy: (PLEASE INITIAL)

_____ I acknowledge I was offered a copy of Tazewell County Health Department's Notice of Privacy Policy.

Authorization to Release Information/Financial Responsibility: (PLEASE INITIAL)

_____ I authorize the release of any medical information to the Centers for Medicare and Medicaid Services (CMS), my insurance carrier(s), or other entities necessary to determine insurance benefits or benefits payable for related medical services provided to me by Tazewell County Health Department. I also understand insurance billing is a service provided by TCHD and I am responsible for the entire and/or balance of my bill once my insurance(s) have been billed if there is a balance. Regulations pertaining to Medicare and Medicaid assignment of benefits apply.

Consent to Test/Treat/Provide Services:

I authorize Tazewell County Health Department to provide testing, administer treatment, or provide appropriate services as deemed necessary for the care of the patient named below. I certify that I am the patient, parent or legal guardian of the patient. I have read or have had explained to me information about the vaccines/services to be given today. I have had the opportunity to ask questions that have been answered to my satisfaction. I understand that this record will be maintained by the Tazewell County Health Department and immunizations will also be maintained in a confidential computerized immunization registry, and that I can choose to opt out of the registry by completing an "Opt Out of Registry" form at each immunization visit.

I understand I have the right to revoke this authorization by giving written notice to Tazewell County Health Department. This authorization is in effect for one year from the date below.

Signature: _____ Printed Name of Signee: _____
(Parent or Legal Guardian if Patient is a minor)

Date: _____



TAZEWELL COUNTY HEALTH DEPARTMENT
 CONSENT FORM FOR CHILDREN UNDER AGE 12

LOT STICKER

Person receiving vaccine:

Last Name _____ First Name _____ Middle Initial _____

Date of Birth ____/____/____ Gender: Male Female Other Unknown

ETHNICITY

Non-Hispanic/Non-Latino

Hispanic/Latino

Unknown

RACE

White

Hispanic/Latino

Native Hawaiian or other Pacific Islander

Black/African-American

American Indian/Alaska Native

Asian

Other

Unknown

PLEASE ANSWER ALL QUESTIONS

		YES	NO	DON'T KNOW
1.	Is your child feeling sick today or had a fever within the last 48 hours?			
2.	Has your child ever received a dose of COVID-19 vaccine?			
3.	Has your child had a positive COVID-19 test or been diagnosed with COVID-19? If yes, has your child completed the isolation period and is fully recovered?			
4.	Has your child received convalescent plasma or passive antibody therapy as treatment for COVID-19? If yes, what was the date? _____			
5.	Does your child have a bleeding disorder or take a blood thinner?			
6.	Has your child ever had a severe allergic reaction to anything listed below? (Severe reaction includes anaphylaxis or hives/swelling/wheezing/difficulty breathing within 4 hours that required a hospital visit or treatment with an Epi-Pen.)			
6a.	A component of the COVID vaccine (Polysorbate or Polyethylene Glycol, found in laxatives or colonoscopy prep medications)			
6b.	Any other vaccine or an injectable medication			
6c.	Food, pets, an environmental irritant, or oral medication			

Your signature on the back of this form verifies that you have read and understand the questions above, and have answered the questions to the best of your knowledge.

NURSING STAFF ONLY:

RECOMMENDED OBSERVATION PERIOD 15 MINUTES 30 MINUTES (for reaction in #6c)

DATE GIVEN: _____ RIGHT DELTOID LEFT DELTOID OTHER _____ DOSE 1

TIME GIVEN: _____ TIME RELEASED AFTER OBSERVATION: _____ DOSE 2

Administering Nurse Signature _____ Date: _____ DOSE 3

Patient/Parent/Guardian provided: _____ BOOSTER

_____EUA Fact Sheet _____Vaccination Card _____Return Date _____Comfort Care _____V-Safe Info